

EAP Lifestyle Management, LLC
1.800.788.2077
eaplifestyle@EAPLifestyle.com

Affiliate Provider Procedures

- EAP Lifestyle Management, LLC will contact affiliate with referral.
- EAP Lifestyle Management, LLC will fax Authorization Form to provider.
- EAP Lifestyle Management, LLC referred client will contact Affiliate to schedule appointment. (Affiliate is not to leave any messages for appointments or any other reason, without expressed permission of client. If client is a minor according to state law, proof of guardianship is necessary, when indicated, before seeing minor for an individual session.)
- At first session/office visit, Affiliate requests clients to complete the following forms
 - Notice of Information (NOI) Practices Acknowledgement Form (Affiliate downloads copy of EAP Lifestyle Management, LLC NOI Practices at www.EAPLifestyle.com and offers to each client or legal guardian.
 - Client Information Form
 - Statement of Understanding
 - Release of Confidential Information
 - Affiliate Provider office staff. Will fill out the client name, provider's name, and expiration date (year from that day)
 - Must be signed by client and witnessed
 - EAP Participant Survey (to be completed by each client at conclusion of first session/office visit)
- Affiliate completes Intake using EAP Lifestyle Management, LLC Intake Form or own Intake Form.
- Affiliate faxes the following forms to EAP Lifestyle Management, LLC at 251.621.5361 upon completion of first session/office visit
 - **NOI Acknowledgement**
 - **Consent for Release of Info**
 - **Ct. Information Form**
 - **Statement of Understanding**
- For Affiliate Reimbursement, all forms must be submitted to EAP Lifestyle Management, LLC. Additional forms required are
 - EAP Lifestyle Management, LLC Contact Form (to be submitted monthly via fax to EAP Lifestyle Management, LLC at 251.621.5361)
 - EAP Lifestyle Management, LLC Billing Form (Billing Form may be submitted weekly, monthly, or at case closure.)

Affiliate may copy forms as needed.



EAP Lifestyle Management, LLC
800.788.2077
www.EAPLifestyle.com

Statement of Understanding

Welcome to the Employee Assistance Program!

I understand that Employee Assistance is a free and confidential service for employees and immediate members who are experiencing personal problems.

I understand that during a confidential interview with a consultant, problems will be identified. If specialized or long-term treatment is necessary, referral will be made to the appropriate resource. I understand that assistance is available for marital, family, Emotional, Alcohol, drug, financial, legal, and job problems.

I understand that information shared with EAP consultant will be strictly confidential except for the following:

- 1) Child Abuse
- 2) When danger exists to the self or others
- 3) Court subpoenas (rarely occurs but is possible)

I understand that Employee Assistance is available at no cost. Only when individuals are referred to a community resource will they be responsible for treatment charges. Medical insurance may cover a portion of the cost for additional help required. When making referrals to an appropriate community resource, the EAP consultant will be sensitive to an individual's financial status and available coverage.

If it is my child or ward who will be receiving services, I hereby give my consent for such services.

Please sign if you understand this information.

Signed: _____

Witnessed: _____

Date: _____



EAP Lifestyle Management, LLC
 800.788.2077
www.EAPLifestyle.com

Client Information Form

Welcome to the Employee Assistance Program! We hope the program will help you as it has many others. Please fill out the following

Name: _____ Date: _____
 Address: _____
 City: _____ State: _____ ZIP: _____
 Phone: Home: _____ Work : _____ Cell : _____

 (OK to leave message: yes or no?) (OK to leave message: yes or no?) (OK to leave message: yes or no?)
 S.S.#: _____ Date of Birth (mm/dd/yr): _____

Please Check One:
 1) Employee ____ Spouse ____ Dependent ____
 2) Male ____ Female ____
 3) Single ____ Married ____ Divorced ____ Separated ____ Widowed ____
 If married, how long: _____
 4) Children: (Sex & Age)

Company: _____ Job Title: _____
 Date of Hire: _____ Work Site/Department: _____
 Your Health Insurance Company: _____

Check Information Source:
 EAP Card/Brochure ____ EAP Orientation ____ Word of Mouth ____
 Friend/Relative ____ Supervisor ____ Medical Dept ____ Personnel Office ____
 Other(specify) _____

List in order of importance the problem(s) for which you are seeking help and circle the level (Mild, Moderate, or Extreme) you are experiencing of that problem.

_____ Mild Moderate Extreme
 _____ Mild Moderate Extreme
 _____ Mild Moderate Extreme

List the kinds of treatment (if any) received for this problem(s).

Please Circle Those Items That You Are Experiencing.

Loss of pleasure	Feeling fearful
Loss of interest in sex	Trouble falling asleep
Guilt	Irritability
Wishing you were dead	Discouragement about future
Drinking too much alcohol	Others worried about your drinking
Used drugs not for medical reasons	Anxious or worried for 6 months or more
Feeling sad	Fear of going crazy
Drugs caused problems in family, work	Feeling suicidal
Fatigue	Crying
Trouble concentrating	Trouble staying asleep
Depression	Unhappiness
Boredom	Sudden attacks of panic or fear

In the last month, how would you say you or your wife/husband/partner got along?

Very well _____ Not well _____ Fairly well _____ Very poorly _____ No Partner _____

Check the sentence that describes your frequency of drinking alcoholic beverages.

___ I never drink any alcoholic beverages.

___ In a typical week, I might not drink any alcoholic beverages. I just drink once in a while.

___ In a typical week, I usually drink some alcoholic beverage.

Do you smoke marijuana or use any addicting drugs? Yes _____ No _____

List any medications you are taking:

What best describes your mental health in the LAST MONTH?

Excellent_____ Good_____ Fair_____ Poor_____

Request for other ways of communicating with me:

I do not need to provide any reason and simply request the following alternatives to or limitations on communicating with me by you or this practice:

1. Please telephone me ONLY at this number(s):

When you call please follow these directions:

_____ Please do NOT telephone me at this number(s): _____

Please direct all postal mail to this address: _____

Please do NOT send postal mail to this address:

3. You may e-mail to me at this address:

Signature of client or his/her personal representative: _____

Date: _____



EAP Lifestyle Management, LLC
1.800.788.2077
www.EAPLifestyle.com

NOI Acknowledgement

I have been offered EAP Lifestyle Management, LLC Notice of Information Practices to read, posted in the offices of EAP Lifestyle Management, LLC. I **DECLINE / ACCEPT** (Circle one) my right to have a copy of EAP Lifestyle Management, LLC Notice of Information Practices.

Signature

Date

Print Name

Witness

* If client indicates they **accept** their right to have a copy of Notice of Information Practices, client must be provided with such. **Notice of Information Practices** can be downloaded at: www.EAPLifestyle.com



EAP Lifestyle Management, LLC
1.800.788.2077
www.EAPLifestyle.com

Consent for the Release of Confidential Information

I, _____, authorize EAP Lifestyle Management, LLC to exchange information with _____ for the purpose of billing and case management.

(Specific Information to be released) _____

Any required for provider reimbursement and case management

I understand that my records are protected under Federal Law. This authorization may be withdrawn at any time in writing except to the extent action has already been taken. Upon revocation of consent, further release of information shall cease immediately. File copy is considered equivalent to the original. This release of information will expire on _____.

I further acknowledge that the information to be released was fully explained to me and his consent is given of my own free will.

Executed this _____ day of _____, 20____

Witness _____ Client _____

Parent of Legal Guardian _____

Prohibition or Redisclosure

This information has been disclosed from records whose confidentiality is protected by Federal Law. Federal regulations (42CFR Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal Rules restrict any information to criminally investigate or prosecute any use if the information to criminally investigate or prosecute any alcohol or drug abuse patient. (42CFR Part 2 applies only to substance abuse records.)



EAP Lifestyle Management, LLC
Phone:(251) 621-5360 Fax: (251) 621-5361
www.EAPLifestyle.com

EAP Participant Survey

We care about your satisfaction with the EAP and strive to provide each person the highest possible quality of service. By filling out this survey, you will help us maintain that quality. This is an anonymous survey so you do not need to sign it. Thank you for your help.

Company: _____

EAP Counselor: _____

I am: _____ an employee _____ a family member _____ other

Please check one for each:

- | | Very Satisfied | Satisfied | Disatisfied |
|---|----------------|-----------|-------------|
| 1. <i>My initial call was responded to promptly</i> | _____ | _____ | _____ |
| 2. <i>The EAP was knowledgeable and helpful</i> | _____ | _____ | _____ |
| 3. <i>The office environment was comfortable</i> | _____ | _____ | _____ |
| 4. <i>My concerns were handled in a confidential manner</i> | _____ | _____ | _____ |
| 5. <i>I was satisfied with the outcome of my visit(s)</i> | _____ | _____ | _____ |
| 6. <i>Overall, were you satisfied with EAP?</i> | Yes_____ | No_____ | |
| 7. <i>Would you use the program again?</i> | Yes_____ | No_____ | |
| 8. <i>Would you recommend the program to a friend?</i> | Yes_____ | No_____ | |
| 9. <i>Comments or suggestions:</i> | | | |

Intake

Client Name _____ Date _____

Presenting Problem (duration, intensity, precipitating event):

Family History (abuse, violence, losses):

Client Marital or Relationship History:

Psychiatric History (DX hospitalizations, OP, dates duration, response):

Medical History (medications):

Trauma History:

Work Issues (Disab., LOA, WC, litigation, warning, suspension, relations w/ co-workers and/or supervisors.) :

Mental Status (speech, mood & affect, orientation, thought process, judgment, memory):

Suicide/Homicide Ideation, Plan Attempt, HX, Threat of Violence:

Sleep / Appetite:

Drug / ETOH History:

CD Tx:

Finances / Legal:

Support Systems:

Cultural Issues:

Rec/Leisure:

Religion/Spiritual:

Other Issues :

DSM IV Diagnostic Impression (Defer, Provisional)

Axis I	
Axis II	
Axis III	
Axis IV	Stressors: Severity:
Axis V	Current GAF: Highest GAF past year:

Plan Recommendation :

Client Instruction for F.U.:

Counselor:



www.EAPLifestyle.com

251-621-5360

eap@EAPLifestyle.com

EAP LIFESTYLE MANAGEMENT, LLC
1048 STANTON ROAD, SUITE F DAPHNE, ALABAMA 36526
(251) 621-5360 FAX (251) 621-5361

BILLING FORM

Client Name: _____

Client Company: _____

Affiliate Provider Name: _____

Tax ID Number: _____ (or) SSN: _____

Address: _____

City/State/Zip: _____

Phone Number: (____) _____

Date(s) of Office Visits: _____

Total Amount Due: _____

Issue Resolved? Yes / No

Client was referred? Yes / No

State Referral Source: _____

Additional Comments: _____

Thank you for your assistance!

Signature / Credentials

Printed Name / Credentials

Date Submitted

Under: Aff Case Closure blank

FOR OFFICE USE ONLY
EAP Lifestyle Management,
LLC to complete:
* Date record: _____
* Date paid: _____
*EAP Lifestyle Management, LLC
staff must complete upon receipt.